Dear Patient,

Welcome to University Rheumatologists. We are located at 1611 West Harrison Street, Suite 510 of the Orthopedic Building at Rush University Medical Center. Directions have been included for your convenience. Parking is available at the garage on the corner of Paulina and Harrison Street. If you park in this garage we are able to validate your ticket for a discounted rate, please inquire at our front desk. Valet parking is also available in the front of the Orthopedic Building but not at a discounted rate.

Please arrive 15 minutes prior to your appointment time to complete the registration process. Rush University Medical Center provides interpretive services when advance notice is given. If you require an interpreter, or need to change or cancel an appointment please call us at 312-563-2800 and press 1. We request that you notify us of your change or cancellation no less than 24 hours in advance. A timely notification will permit patients that are waiting to schedule a sooner appointment. If you fail to notify us at least 24 hours prior to your appointment time, it may result in being discharged from the practice.

We want your visit with us to be a success. Therefore, we have included a checklist to help you prepare for our time together. Please bring the completed packet with you on your appointment date. This will reduce your registration time on the day of your visit.

Thank you for choosing University Rheumatologists. We look forward to seeing you and participating in your care.

Sincerely,

University Rheumatologists
New Patient Checklist

Prior to Your Visit:

☐ FAX Copies of medical records. This includes physician progress notes, blood tests, x-ray reports or any other tests that might be of helpful to your doctor. Please send to Attention: NP Medical Records (Fax) 312-563-2075 or to the Address on the front of this packet. If unable to access a fax machine please bring the records with you to your visit.

Bring to Your Visit:

☐ A list of all current medications or the actual pill bottles (names, doses, frequency)

☐ Please bring your current insurance card and photo ID to each visit.

☐ Your co-pay (look on your insurance card for amount) will be collected upon check-in at each visit. We accept cash, check, Visa, MasterCard, American Express and Discover credit cards.

  • If you will not be using insurance, please be prepared to pay the full fee for services. A discount of 50% will be offered on the professional fee and 65% off the facility fee only if you pay in full on the same day service was provided.

☐ If you have a HMO/Managed care plan: Please obtain a referral prior to your visit from your primary care physician and bring it with you. The referral must be valid for the date of your appointment and should indicate the services authorized.

  • Do you need a referral or authorization?

      ☐ Yes       ☐ No

Forms Attached (Please fill out and bring with you):

☐ Authorization for release of patient health information. This is provided in case it is needed by outside facilities to send our office records. This can also be filled out to request records from our facility (that occurred prior to or on the signature date) to be sent elsewhere.

☐ Authorization for Use and Disclosure of Protected Health Information for Fundraising and Related Communication (This form is optional).

☐ Multi-Dimensional Health Assessment Questionnaire: Only the last 2 pages are included (3-4). Please fill these out prior to your appointment.
# New Patient Checklist

## PHARMACY

**Retail Pharmacy**

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
<th>Address/Intersection</th>
</tr>
</thead>
</table>

**Mail-order Pharmacy (If Applicable)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
<th>Address/Intersection</th>
</tr>
</thead>
</table>

## PHYSICIANS

**Primary Care Physician**

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
<th>Address/Intersection</th>
</tr>
</thead>
</table>

**Physician that referred you today**

[ ] Same as PCP

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
<th>Address/Intersection</th>
</tr>
</thead>
</table>
RUSH UNIVERSITY MEDICAL CENTER
AUTHORIZATION FOR RELEASE OF
PATIENT HEALTH INFORMATION

HIM ROI Authorization
Authorization for Release of
Patient Health Information

INSTRUCTIONS: This authorization is made by you for the release of your healthcare information, as indicated. Please address questions about this form to: Rush University Medical Center, ATTN: Health Information Management Office, 1611 West Harrison Street, L1, Suite 001, Chicago, IL 60612, Telephone: (312) 942-7262, Fax: (312) 942-2264.

SECTION 1: Patient Information

Name [Last, First, MI] ____________________________________________

Date of Birth: ________________________________

Address [Street, City, State, Zip] _______________________________________

Phone Number(s): Home Cell Business Medical Record Number [if known] Social Security Number (Last 4) XXX-XX- _______ ______

SECTION 2: Authorized to Request Use or Disclosure (FROM)

I request that my medical record information be sent FROM the person(s)/location(s) indicated below

Name [Last, First, MI] ____________________________________________

Organization ____________________________________________________

Address [Street, City, State, Zip] _______________________________________

Phone Number(s): Home Cell Business Fax _______________________________________

SECTION 3: Authorized Recipient to Receive (TO)

I request that my medical record information be sent TO the person(s)/location(s) indicated below

If you are requesting access to your own medical record, please fill in your own personal information

Name [Last, First, MI] ____________________________________________

Organization ____________________________________________________

Address [Street, City, State, Zip] _______________________________________

Phone Number(s): Home Cell Business Fax _______________________________________

SECTION 4: Purpose of the Use or Disclosure

The use or disclosure of my health information is requested for the following purposes (such as continuing care, attorney, sell, employer, other):

SECTION 5: Information to be Disclosed

The following type of information is authorized for release [initial next to each type] for the period of ____________ to ____________:

☐ General Medical _______________________________________________

☐ Substance Abuse _______________________________________________

☐ HIV Records __________________________________________________

☐ Mental Health and Developmental Disability Treatment Records ____________

☐ Genetic Testing Records _________________________________________

☐ Other _________________________________________________________
RUSH UNIVERSITY MEDICAL CENTER

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient Name: ____________________________
Date of Birth: ____________________________
Medical Record #: ________________________

SECTION 6: Disclosure to Include

This disclosure will include the following types of reports:

- X-Ray/Radiology Report
- Operative Report
- History and Physical
- Pathology Report
- Emergency Report
- Consulting Report
- Immunization Record
- Itemized Bill
- Progress/Physician Notes
- Discharge Summary
- EKG/EEG/EMG Report
- Films/Slides
- Other:
- Laboratory Report

SECTION 7: Authorization Expiration Date

This authorization is approved for:

- This occurrence only
- 90 days from the date of signature
- On occurrence of the following event (which must relate to the individual or to the purpose of the use or disclosure being authorized):

SECTION 8: Please read the following statements carefully:

This authorization is voluntary. Rush will not condition your treatment on giving this authorization. However, Rush may condition the provision of research-related treatment on the provision of an authorization.

I understand that I may change my mind and revoke this authorization at any time by giving written notice of my revocation to the contact office listed above. I understand that revocation of this authorization will not affect action you took in reliance on this authorization before you received my written notice of revocation.

I authorize the use and/or disclosure of my Protected Health Information (PHI) as described above. I understand that this authorization is voluntary and made to confirm my decision so Rush may use and/or disclose my PHI for a specific purpose. I understand that, if the persons or organizations authorized above to receive and/or use the PHI described above are subject to federal health information privacy laws, they may further disclose the PHI and it may no longer be protected by federal health information privacy laws. However, any mental health, substance abuse, genetic testing, or HIV/AIDS information disclosed by Rush pursuant to the authorization may not be further disclosed except pursuant to my authorization.

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to you. I understand that, by signing this form, I am confirming my authorization that you may use and/or disclose to the persons and/or organizations named in this form the PHI described in this form.

SECTION 9: Signature

Patient Signature

Personal Representative Name [Last, First, MI]

Personal Representative Relationship to Patient and Authority:

Personal Representative Signature

Witness Name [Last, First, MI] [Required for the release of mental health information]

Witness Signature

SECTION 10: Verification of Authority

How is the person's identity, authority, and relationship to the patient authorized?

- Personal Identification
- Government credentials
- Authority is known
- Personal representative status (identify as parent, guardian, executor, administrator, power of attorney)
- Warrant, subpoena, order, summons, civil investigation, or other legal process

Copy provided to the individual
Authorization for Use and Disclosure of Protected
Health Information for Communications and Fundraising Opportunities

Patient’s Name ____________________________________________

Street Address _____________________________________________

City/State/Zip ______________________________________________

Phone ___________________________ Birth Date: ________________

E-mail ________________________________

Physician/Practice _________________________________

I authorize Rush University Medical Center (RUMC) to use and disclose the name of my physician and the name of the department in which I was treated. Information regarding my medical condition, diagnosis or treatment will not be disclosed.

I understand that this authorization will permit RUMC to provide me with relevant information on health care issues and programs through newsletters, publications, and other materials. In addition, I understand I may be contacted about opportunities to provide charitable support to RUMC in the areas pertaining to my personal health concerns.

RUMC fully supports the protection of health information. My name will not appear on any patient list that will be loaned or sold by RUMC or its medical practices nor will my name be used for telemarketing purposes.

My authorization is voluntary. My failure to sign this authorization will not affect my treatment, payment or eligibility for benefits in any way.

This authorization is valid until revoked. I may revoke this authorization at any time by submitting a request in writing to Rush University Medical Center, Philanthropy Office, 1700 W. Van Buren, Chicago, IL 60612. The revocation will be effective except to the extent that RUMC has already relied on my authorization.

Signature (patient or authorized representative) ____________________________ Date ______________________

For office use only:
EPIC MR# ______________

Approved by the Rush Privacy Office September 2011
16. Please check (✓) either “No” or “Yes” to indicate whether or not you have any of the conditions below:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Age or Year</th>
<th>Condition</th>
<th>Age or Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Blood Pressure or Hypertension</td>
<td></td>
<td>Gynecological (Female)</td>
<td></td>
</tr>
<tr>
<td>Heart attack</td>
<td></td>
<td>Prostate (Male) problem</td>
<td></td>
</tr>
<tr>
<td>Other heart disease</td>
<td></td>
<td>Rheumatoid arthritis</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td>Osteoarthritis</td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
<td>Lupus</td>
<td></td>
</tr>
<tr>
<td>Bronchitis or Emphysema</td>
<td></td>
<td>Back or spine problems</td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td>Fibromyalgia (Fibrositis)</td>
<td></td>
</tr>
<tr>
<td>Other Lung problem</td>
<td></td>
<td>Osteoporosis</td>
<td></td>
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<tr>
<td>Anemia (Low Blood)</td>
<td></td>
<td>Broken bones</td>
<td></td>
</tr>
<tr>
<td>Other hematologic problem</td>
<td></td>
<td>Dry mouth</td>
<td></td>
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<tr>
<td>Stomach ulcer</td>
<td></td>
<td>Dry eyes</td>
<td></td>
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<tr>
<td>Other gastrointestinal (GI problem)</td>
<td></td>
<td>Cataracts</td>
<td></td>
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<tr>
<td>Thyroid problem</td>
<td></td>
<td>Parkinson’s disease</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td>Depression</td>
<td></td>
</tr>
<tr>
<td>Kidney problem</td>
<td></td>
<td>Mental illness</td>
<td></td>
</tr>
<tr>
<td>Severe allergies</td>
<td></td>
<td>Alcoholism</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
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</tbody>
</table>

17. Please list below all operations you have ever had. Please check (✓) here if none: 

<table>
<thead>
<tr>
<th>Operation</th>
<th>Year</th>
<th>Surgeon</th>
<th>Hospital, City, State</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

18. Please list below all major illnesses or hospital admissions (other than for operations). Please check (✓) here if none: 

<table>
<thead>
<tr>
<th>Illness or Reason for hospitalization</th>
<th>Year</th>
<th>Hospital, City, State</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

19. The questions below concern your family medical history:

<table>
<thead>
<tr>
<th>If Living</th>
<th>If Deceased</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Year or Age</td>
<td>Any Major Medical Conditions</td>
</tr>
<tr>
<td>Father</td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
</tr>
<tr>
<td>Brother(s)</td>
<td></td>
</tr>
<tr>
<td>Sister(s)</td>
<td></td>
</tr>
<tr>
<td>Son(s)</td>
<td></td>
</tr>
<tr>
<td>Daughter(s)</td>
<td></td>
</tr>
</tbody>
</table>

20. Any blood relative (parent, child, brother, sister, aunt, uncle) with: If “Yes”, give relationship.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>Relation(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatoid Arthritis</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Lupus or SLE</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

21. Any illnesses which run in the family?
22. Please write below all pills that you took over the last TWO WEEKS, with or without a prescription. Include aspirin, birth control pills, pain pills, alternative therapy, health supplements, pills sold in health food stores:

<table>
<thead>
<tr>
<th>NAME OF DRUG, MEDICINE OR ALTERNATIVE THERAPY</th>
<th>DOSE (if known)</th>
<th>How Many per day or week?</th>
<th>NAME OF DRUG, MEDICINE OR ALTERNATIVE THERAPY</th>
<th>DOSE (if known)</th>
<th>How Many per day or week?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<td>8.</td>
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<tr>
<td>2.</td>
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<td>9.</td>
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<td>3.</td>
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<td>10.</td>
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<td>4.</td>
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<td>11.</td>
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<td>5.</td>
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<td>12.</td>
<td></td>
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<tr>
<td>6.</td>
<td></td>
<td></td>
<td>13.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td></td>
<td>14.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

23. What is your current occupation? (If you are not working now, what was your past occupation?)

______________________________

24. How many other people live at home with you? ___

[Please check (√) who lives with you.]

Spouse/partner ___Parents ___
Sons or daughters ___I live alone ___
Others (describe) ___

25. At this time, are you? [Please check (√) all that apply.]

√ Working full time ___Retired ___
√ Working part time ___Student ___
√ Homemaker-full time ___Disabled ___
Others (describe) ___

26. How many years of school have you completed?

Please circle the number of years of school.

1  2  3  4  5  6  7  8  9  10
11 12 13 14 15 16 17 18 19 20

Your Name ________________________
First   Middle   Last

Today’s Date ______________________
Time of Day ______________________ AM | PM

Date of Birth ______________________

SEX: ☐ Female ☐ Male ☐ Ethnic ☐ Asian ☐ Hispanic ☐ Other ☐ Marital Status: ☐ Single ☐ Married ☐ Divorced
☐ Widowed ☐ Separated

Please check if this questionnaire is completed entirely by patient ☐ or with help from (name) ______________________

WE ASK YOU FOR CONSENT TO REVIEW YOUR RECORDS FOR MEDICAL RESEARCH AND TO CONTACT YOU IN THE FUTURE. YOUR CARE WILL NOT BE AFFECTED IF YOU ANSWER "NO."

I agree to allow information from my medical record to be reviewed for medical research, and to send me similar questionnaires in the future, which I am not required to answer. I understand that this information will remain confidential with my doctor and his or her research associates only. Please check (√) in one box. Thank you!

☐ YES ☐ NO Signature ______________________ Date ______________

Please list the name, address, and telephone number of your primary care physician:

Name ______________________ Address ______________________
City, State ZIP ______________________ Telephone ______________________

Please list the name of your rheumatologist and insurance center:

Rheumatologist ______________________ Insurance ______________________

Please list the name, address, and telephone number of someone who lives at a different address from you, and who will be likely to know your whereabouts if we are unable to reach you:

Name ______________________ Address ______________________
City, State ZIP ______________________ Telephone ______________________ Relationship ______________________

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE TO MONITOR YOUR MEDICAL SITUATION.